

<b>Case Number:</b>	CM14-0039303		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	01/23/2006
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant was injured on 01/23/06. An MRI of the lumbar spine dated 05/05/08 revealed minimal disc degeneration at L2-3 and L3-4 with no stenosis. The claimant underwent bilateral L4-L5 transforaminal epidural steroid injections on 05/02/13. On 05/23/14, she had low back pain radiating to the lower extremities that was rated 7-8/10 with medication and 9/10 without medication. She had limited motion and myofascial tenderness. There was no change in the sensory or motor exams. Additional injections were requested. She received B12 and Toradol injections. An MRI was awaited. On 06/18/13, she reported an average pain level of 7-9/10 with medication and 9-10/10 without medication. She had decreased range of motion due to pain with vertebral and myofascial tenderness. Her sensory and motor exams were not changed. She received a B12 injection and Toradol injection. She was to continue her exercise program. On 02/04/14, a pain management reevaluation indicated spasm bilaterally with tenderness and decreased range of motion. She had normal sensation and mildly decreased strength in the lower extremities. She had absent Achilles and patellar deep tendon reflexes bilaterally. She had a straight leg raise that was positive in the seated position bilaterally at 60. She requested a repeat epidural steroid injection which she stated helped her a lot. There is no documentation of an ongoing exercise program. Similar findings were noted on 03/11/14. She received trigger point injections and a Toradol injection. A note by [REDACTED] dated 04/08/14 indicates that the claimant had improved low back pain after an epidural injection at L4-5 on 05/02/13 for 2-3 months. She had been diagnosed with lumbar radiculopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

## **Bilateral L4-5 Transforaminal Epidural: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79.

**Decision rationale:** The history and documentation do not objectively support the request for repeat bilateral L4-5 epidural steroid injections. The MTUS state epidural steroid injections may be recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) There is no clear objective evidence of radiculopathy bilaterally at L4-5 on physical examination and no EMG was submitted. The MRI report does not indicate the presence of nerve root compression bilaterally at the level to be injected. There is no indication that the claimant has been instructed in home exercises to do in conjunction with injection therapy. Of note, the claimant had an epidural steroid injection on 05/02/13 but 3 weeks later, she still had high pain levels and received vitamin B12 and Toradol injections. There is no evidence of 2-3 months of significant pain relief following the injections at the same level in May 2013. Therefore, the medical necessity of repeat injections has not been demonstrated.